STATEMENT OF CONSIDERATION
RELATING TO
803 KAR 25:091
DEPARTMENT OF WORKERS' CLAIMS
AMENDED AFTER COMMENTS

(1) A public hearing on 803 KAR 25:091 was held on January 22, 2009, at the Department of Workers' Claims. Written comments were received and comments were made at the hearing.

(2) The following persons attended the hearing:

(a) Angela P. Miller, AXIS Medical Management, LLC
amiller@axismm.com

(b) Jim Meyers, Norton Healthcare
Jim.meyers@nortonhealthcare.org

(c) Elizabeth North, Baptist Healthcare
elizabeth.north@bhsi.com

(d) Shawn Conley, Van Antwerp, Monge, Jones & Edwards
sconley@vmje.com

(e) Armer Mahan, Underwriters Safety & Claims
amahan@uscky.com

(f) Gary Gilmour, Underwriters Safety & Claims
gary@uscky.com

(g) Steve Miller, Kentucky Hospital Association
smiller@kyha.com

(h) Brian Brezosky, Kentucky Hospital Association
bbrezosky@kyha.com

(i) Nancy Galvagni, Kentucky Hospital Association
ngalvagni@kyha.com

(j) Kelly Reynolds, Kentucky Hospital Association
kreynolds@kyha.com

(k) Karen Greenlee, Kentucky Hospital Association
kgreenlee@kyha.com

(l) Veada Metcalf, Ladegast & Heffner Claims Service
vmetcalf@lhclaims.com

(m) Mary Margaret Sutherland, Ladegast & Heffner for Kentucky AGC Self-Insurers
msutherland@lhclaims.com

(3) The following personnel from the administrative body were present:

(a) Dwight T. Lovan, Commissioner, Department of Workers' Claims

(b) Thomas A. Dockter, Staff Attorney, Department of Workers' Claims

(c) Lucretia Johnson, Division Director, Department of Workers' Claims

(d) Pam Knight, Department of Workers' Claims

(e) Carole Jacobs, Department of Workers' Claims

(f) Karen Meier, Staff Attorney, Department of Workers' Claims

(g) Leanne Diakov, Staff Attorney, Department of Workers' Claims

(h) Candace Sacre, Department of Workers' Claims

(4) The following persons submitted written comments:

(a) Mary Jean Riley, North American Stainless, 6870 Highway 42 East, Ghent, Kentucky 41045

(b) Armer H. Mahan, Jr., Underwriters Safety and Claims, 1700 East Point Parkway, Louisville, Kentucky 40223

(c) Carl W. Breeding, Greenebaum, Doll & McDonald, PLLC, 229 West Main Street, Suite 101, Frankfort, Kentucky 40601

(d) Angela Pannell Miller, AXIS Medical Management, LLC

(e) Nancy Galvagni, Kentucky Hospital Association

(f) Veada Metcalf, Ladegast & Heffner Claims Service, Inc., 320 North Evergreen Road, P O Box 436949, Louisville, Kentucky 40253-0649

(g) Jim Meyers, Norton Healthcare, P.O. Box 35070, Louisville, Kentucky 40232-5070

(h) John Henson, Baptist Regional Medical Center, 1 Trillium Way, Corbin, Kentucky 40701

(i) Russ Ranallo, Owensboro Medical Health System, P.O. Box 20007, Owensboro, Kentucky 42304-0007

SUMMARY OF COMMENTS AND RESPONSES

(1) SUBJECT MATTER: Unbundling.

(a) Comment: This amendment to this regulation relates to the removal of the prohibition against "unbundling" in Section 9 of the regulation. In conjunction with this change, the definition of "unbundling" and "global basis" were also removed from the definitional section of the regulation. Since much of the discussion at the hearing and in the written comments submitted deal with this issue, the comments will be addressed separately by individual and grouped by those opposing it and supporting it.

1. Armer H. Mahan, Jr., Underwriters Safety and Claims, Inc., strongly opposed this amendment. Mr. Mahan testified both at the hearing

and supplied written comments as a follow-up thereto. He stated that the statutory interpretation of the removal of the definitions of both "unbundling" and "global basis" along with the removal or the prohibition against unbundling, would be interpreted as being an approval by the Department of Workers' Claims of the unbundling of charges by the hospitals. This would be contradictory to the express provisions of the Cabinet for Health and Family Services, Department for Medicaid Services, Regulation at Title 907, Chapter 1, Regulation No. 671 (907 KAR 1:671), which defines "unbundling" as an unacceptable practice.

Mr. Mahan further indicated that unbundling of charges is a practice that is condemned by the U.S. Centers for Medicare and Medicaid Services (CMS). He cites Version 11.3 of the National Correct Coding Initiative Policy Manual for Medicare Services and Version 14.3 as further regulatory prohibition of the practice of unbundling. Based upon this information, Mr. Mahan indicated that the practice of "unbundling" should not be approved by the Department of Workers' Claims through the amendment to 803 KAR 25:091.

2. Carl W. Breeding, Greenebaum, Doll & McDonald, PLLC, submitted written comments on behalf of the Kentucky Association of Manufacturers ("KAM"). He first indicated that KAM would urge Commissioner Lovan to consider postponing amending this regulation until he had had an opportunity to convene a group for the purpose of reviewing

the entire system and recommending any changes. He opined that the proposed regulatory changes to 803 KAR 25:091 do not accomplish the intent of the Department of Workers' Claims to balance the interest of the hospital with regard to reasonable value for medical services and supply with the interest of the employers who are by law required to pay for the treatment of work-related injuries and disease.

As it relates to the changes addressing "unbundling", Mr. Breeding noted that the deletion of this requirement along with the deletion of the definition of "global basis" encourages providers to bill separately for items which are necessarily included in the cost and charges of other line items, thus unfairly increasing the amount of charges to which the calculated costs-to-charge ratio applies. Therefore, the change would permit a provider to receive more reimbursement based on the greater number of line items the provider generates in the bill, *whether or not the cost and reimbursement for the additional line items has been covered in the reimbursement of another line item.* He added that such additional billing will necessarily increase medical costs across the board of workers' compensation claims and adversely affect Kentucky's ability to attract and retain employers, as the cost-to-charge ratio in and of itself does not eliminate a provider's ability to increase the number of line items billed.

Mr. Breeding further reiterated and reasserted the legal consequences of the change in the prohibition of unbundling, similar to Mr. Mahan, and

made reference to both the previously mentioned regulations prohibiting the practice by the Cabinet for Health and Family Services, and the Department of Medicaid Services as well as the U.S. Centers for Medicare and Medicaid Services (CMS) regulations.

3. Nancy Galvagni, representing Kentucky Hospital Association, spoke at the hearing and also provided written comments in support of the proposed amended regulation. She indicated that the elimination of unbundling is necessary because prohibition against unbundling is being greatly misused by managed care companies who are "paid based on their ability to generate savings which relates directly to how many charges they can deny on a hospital bill." The deletion of the term will lead to less controversy and litigation since it doesn't matter how a hospital bills, the total charges get reduced to costs whether the charges are itemized separately or are bundled together.

Ms. Galvagni also pointed out that the prohibition against bundling by Medicare and Medicaid is required because they pay on a DRG basis, which is a global payment, with a set fee. The grouping of certain charges by Medicare and Medicaid in order to satisfy their fee schedule is totally separate and distinct from that of the Kentucky hospital fee schedule.

4. Steve Miller, Kentucky Hospital Association, provided comments at the hearing on this proposed regulatory amendment. He also spoke in favor of removing the prohibition against unbundling. Mr. Miller

referenced the fact that hospital charges for their services are in compliance with the Federal requirements of Medicare and Medicaid billing. He agrees with Ms. Galvagni that there is a difference between how workers' compensation pays in the State of Kentucky as compared to Medicare and Medicaid. Medicare and Medicaid bills are paid based upon DRGs while workers' compensation is paid in accordance with a fee schedule. By utilizing the cost-to-charge method of billing, the two methods of computing charges are equalized.

In reviewing various financial information from the hospitals in the Association, Mr. Miller indicates the overall effect of removing the prohibition against unbundling may result in the hospital's receiving less revenue than the greater amount that some anticipate. Even with this in mind, the Association supports the proposed amendment and does not see it as being in contravention to the rule set forth by Medicare and Medicaid.

5. Jim Meyers with Norton Healthcare, provided comments at the hearing and in writing. He also spoke in support of the proposed changes to the regulations and echoed the fact that some hospitals will actually receive a decreased amount of revenue based upon the changes rather than an increase in revenue. However, more importantly, Mr. Meyers believes that the amount of underpayments due to contested billing which can take 18 months to two years to resolve, will be greatly reduced due to the changes made in the proposed amendments to the regulation. This burden of

correcting underpayments has caused large administrative burdens that will not be present under the anticipated regulation.

6. Elizabeth North spoke on behalf of Baptist Hospital East and Baptist Healthcare System. Speaking on behalf of the five facilities that Baptist Healthcare has throughout the State of Kentucky, Ms. North endorsed 100 percent the KHA statement supporting the regulatory changes. She also echoed the fact that many administrative burdens are placed upon their hospital staffs due to the contestation of charges and underpayment of bills for services rendered under the present system, which she believes would be corrected with the regulatory changes.

(b) Response: With the changes made in the calculation of the cost-to-charge ratio, there would be no reason to prohibit unbundling. The new calculation will bring the charges to the same level whether charges are bundled or not. The base cost-to-charge ratio is based upon a medicine/medical documentation so the proscription against unbundling has been addressed.

Additionally, as noted by the speakers, since "unbundling" is already prohibited by the Cabinet for Health and Family Services, Department for Medicaid Services, and the U.S. Centers for Medicare and Medicaid Services (CMS), there is no need to prohibit it again in the workers' compensation regulation.

(2) SUBJECT MATTER: Allowable Charges.

(a) Comment: This amendment relates to the removal of the word "allowable" from the term "allowable charges." This change is made by the Department of Workers' Claims as it is felt that KRS 342.020, which allows for the payment of reasonable and necessary medical expenses is sufficient to regulate which charges are allowable or not. Therefore, the term "allowable" is an unnecessary duplication of phrases relating to medical charges. Again, comments will be organized with those opposing the regulatory change and then followed by those favoring it.

1. Armer Mahan, Underwriter Safety and Claims, opposes this amendment. He indicated that when read together, Section 3(2)(a) and (b) require employers to apply the adjusted cost-to-charge ratio to a hospital's total billed charges unless the billing contains charges for services or supplies that are non-compensable under KRS 342.020. By deleting the word "allowable" from the term "hospital's total allowable charges", DWC has precluded the community of employers from challenging hospital bills which contain charges which should not be allowed. The net result of the change in the regulation is that it precludes employers from even questioning the hospital's total charges, according to Mr. Mahan.

Examples of non-allowable charges would include incidents where services or supplies have been double billed, charges have been unbundled, and where the hospital upon request was unable to provide specific documentation that the service was performed or the supply provided. Mr.

Mahan opined that the proposed regulatory change would have the further effect of precluding employers from making inquiry regarding or obtaining information pertaining to alleged or suspected hospital billing errors.

The net effect, according to Mr. Mahan, is that the proposed change will not reduce the number of medical fee disputes or motions to reopen regarding medical issues, but will serve to increase the workers' compensation expenses of Kentucky employers and will impair or eliminate the ability of representatives of Kentucky employers to work with hospital personnel in reducing or deleting erroneous charges.

2. Carl W. Breeding, Greenebaum, Doll & McDonald, PLLC, also submitted comments opposing the rule of the word "allowable" as it relates to medical charges. Mr. Breeding's comments regarding the proposed regulations were the same as Mr. Mahan's. The net effect of this proposed regulation would be to increase workers' compensation expenses of Kentucky employers and could impair their ability to work with hospital personnel in reducing or deleting erroneous charges which, in turn, could lead to an increase in litigation.

3. Nancy Galvagni, Kentucky Hospital Association, provided both oral and written comments in support of this regulatory change. She stated that the term "allowable charges" has been greatly misused by managed care companies that are paid on the basis of how many things they can deny on a hospital bill. The more things that they can deny, the more money they

can make. Therefore, it is in their best interest to come up with as many ways as possible to deny things. She did not believe that people were looking at billing errors or double-billing or services not being rendered, as hospitals have no problem making corrections for that, but they are talking about denying medically necessary services.

Inappropriate denial of legitimate charges by managed care organizations result in financial losses for Kentucky's hospitals and should be stopped by passage of the proposed amendment, according to Ms. Galvagni. Hospital charges should only be denied if treatment is for a non-compensable injury or if treatment has been determined as not medically necessary pursuant to a valid utilization review performed in accordance with the standards for utilization review.

4. Steve Miller, Kentucky Hospital Association, agreed with the comments made by Ms. Galvagni and supports the proposed change in the administrative regulation.

5. Jim Meyers, Norton Healthcare, also spoke and provided written comments supporting the position of the Kentucky Hospital Association in support of the proposed amendment removing the word "allowable" from the regulation.

6. John Henson, President, CEO, Baptist Regional Medical Center, provided written comments strongly supporting the changes in the

administrative regulation and echoed the opinions of the Kentucky Hospital Association.

7. Russ Ranallo, Owensboro Medical Health System, submitted written comments strongly supporting the deletion of "allowable" charges in Section 3(2)(a) of the proposed rule. He indicated that there are no published guidelines on what makes the charge unallowable. He echoed the fact that hospital charges should only be denied if the treatment for a non-compensable injury or the treatment has been determined that it is not medically necessary in accordance with a valid utilization review performed under the standards for utilization review.

(b) Response: The Department of Workers' Claims has determined that the prohibition against non-compensable medical charges is adequately contained in the statute, KRS 342.020. Because of the specific language of that statute and the many cases interpreting that statute, the use of the term "allowable" in the hospital fee schedule regulation, 803 KAR 25:091, is duplicative and unnecessary. If the medical charges are reasonable, necessary, and caused by the work-related injury, they should be compensable and allowable.

(3) SUBJECT MATTER: Cost-to-Charge Ratio.

(a) Comment: The Department of Workers' Claims amended the calculation method for hospital cost-to-charge ratio which should result in hospital charges being at the same level no matter what markups have been

done by a hospital. The calculation will keep charges consistent and prevent excessive markups on certain services.

1. Mary Margaret Sutherland, Ladegast and Heffner, which is the third party administrator for a group self-insured fund with Kentucky AGC Self-Insurers Fund, raised questions regarding the efficiency of the proposed cost-to-charge ratio amendment. She testified at the hearing that applying the cost-to-charge ratio does not necessarily even out the bottom line cost of the service since many services are marked up dramatically resulting in what she perceived to be an overcharge situation. She also did not believe that KRS 342.035, which is the medical fee schedule, provides the necessary protection to workers' compensation carriers as it does to Medicare. This, because of the markups, can result in workers'' compensation carriers being overbilled at different hospitals for the same or similar procedures.

Likewise, she had questions regarding the use of the term of "acute care" as it relates to the cost-to-charge assigned to new hospitals. She questions whether all of the same or similar facilities will be lumped together and whether an average cost-to-charge ratio will be applied or not.

She questioned whether the cost-to-charge ratio as already being utilized would be put on hold until 2010 rather than being immediately applied. Commissioner Lovan pointed out that these ratios are set statutorily before the end of January of each year.

Ms. Sutherland had further questions regarding out-of-state ambulatory surgery centers and the calculation of the cost-to-charge ratio of those facilities as well as those located in counties contiguous to the county in which the ambulatory surgery center is located. Also, she had a question regarding the determination of the 132% and 138% percentages utilized in the proposed regulation.

2. Carl W. Breeding, Greenebaum, Doll & McDonald, PLLC, provided written comments on behalf of the Kentucky Association of Manufacturers as it relates to the cost-to-charge ratio. He indicated that KAM has no objections to the revised method of determining the applicable cost-to-charge ratio. He stated that the adjusted cost-to-charge ratio is an appropriate tool for balancing the interest of employers and containing escalating workers' compensation expenditures against the needs of facilities to obtain adequate value to sustain growth and improvement in the provision of healthcare services. He further added that this prudential balancing approach is also reflected in the increased range of payment applicable to Level 1 trauma centers through both the higher multiplier applied to the base ratio (138% versus 132%) and the higher cap on the adjusted cost-to-charge ratio (50% versus 50%).

3. Angela Pannell Miller, AXIS Medical Management, LLC, provided comments in writing after the hearing reflecting her opposition to certain aspects of the proposed regulation. Specially, she indicated that it

was stated that by using the cost-to-charge ratio, all charges would be "rolled back" to cost, so that it would not matter what is billed since the overall adjustment would be 132-138% with a cap of 50-60% depending upon the hospital's designation. She stated that this is simply untrue. Ms. Miller provided examples of cases where cost-to-charge in various cost centers is manipulated by hospitals in order to maximize reimbursement. While this is perfectly within their legal rights to do in that manner, represent the ratio in that way is misleading. She further indicated that clinics can mark up their charges, as some already do, in order to maximize their reimbursement and that by simply assigning them a cost-to-charge ratio will do nothing to control their charges and ultimately their payment. For example, a 50% cost-to-charge ratio on a bill of $50,000 does nothing to help when a facility's cost are only $10,000. In that example, payment would be $25,000 when it should be $13,200, according to Ms. Miller.

Ms. Miller indicated that if everyone is truly content with a 32-38% profit for providers, then they should bill by the "actual cost" of each charge, not an overall average. By adding a 32-38% profit to the actual cost of the procedures, through their UB-92 system, a level playing field would be obtained and medical fee disputes would be reduced to nearly nothing and, further, a decrease in staffing needs would also be present due to the reduction in contested bills.

4. Mary Jean Riley, North American Stainless, provided a written comment to Commissioner Lovan regarding the proposed amendments. Ms. Riley indicated that North American Stainless has invested more than $1.5 billion in Kentucky and its 1,370 employees must compete globally. Due to the downturn in the economy, it continues to be very important to control cost. Therefore, Ms. Riley requested the assurance that the proposed amendments will not increase costs.

5. Nancy Galvagni, Kentucky Hospital Association, spoke at the hearing and also provided written comments in support of the proposed amendment regarding the calculation of the cost-to-charge ratio. Realizing this method, a hospital's total billed charges are to be multiplied by that hospital's cost-to-charge ratio, calculated from the facilities Federal Medicare cost report, plus an add-on. Each hospital would have one set of charges for all payers. Utilizing the cost-to-charge method, it would not matter how a facility sets its charges for individual items, how charges vary between facilities or whether some hospitals itemize charges for certain services while other facilities combine them because application of each hospital's individualized cost-to-charge ratio would effectively reduce the total billed charges for that hospital back to that facility's cost. There would be no need to prescribe what a hospital may charge for individual services because the cost-to-charge ratio would reduce all charges regardless of the markup, back to cost.

Ms. Galvagni noted the higher cost-to-charge ratio cap in recognition of hospitals with a higher volume of governmental patients and those that have more than 400 beds and Level I trauma centers in recognition of their higher costs and acuity of workers' compensation patients. The Kentucky Hospital Association supports this revised percentage adjustment as an equitable method for all hospitals because the proposal recognizes, through a higher adjustment, those hospitals providing extremely technical services and treating more acutely ill patients which is integral to the Kentucky workers' compensation system.

6. Jim Meyers with Norton Healthcare, Steve Miller with Kentucky Hospital Association, and Elizabeth North representing the Baptist Healthcare System, all echoed the sentiments of Ms. Galvagni regarding this proposal. This was stated by them at the public hearing held in this matter.

7. John Henson, President, CEO, Baptist Regional Medical Center and Russ Ranallo, Owensboro Medical Health System, also provided written comments strongly supporting the proposed amendment as it related to the cost-to-charge ratio.

(b) Response: By amending the current calculation method for hospital cost-to-charge ratio, the Department of Workers' Claims attempted to address the concerns of all parties who have provided comments to this agency. The method should return the hospital charges to the same level no matter what markups have been done by a hospital and will keep charges

consistent and will prevent excessive markups on certain services. Thus the agency anticipates a reduction in medical fee disputes and litigation. The method presently used in 803 KAR 25:091 results in return or equity of between 25 and 55 percent. Those hospitals with "better" base cost-to-charge ratios actually receive lower return on equity than others. A guarantee of reduction in overall costs cannot be made, but if this approach had been used in 2008, the annual savings to workers' compensation programs would have been $500,000 or more.

(4) SUBJECT MATTER: Submitted General Questions.

Written questions and comments were submitted by representatives of Ladegast & Heffner Claims Service after the hearing. Those questions, comments, and the Department of Workers' Claims' responses are set out hereafter.

Q1. In regard to hospital billing, and quite specifically we are concerned about implants. KRS 342.035 states that charges are to be "fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers". Since contracts between providers and health insurers are so confidential, how can workers' compensation carriers be assured that the billing for a workers' compensation patient is the same as a health insurers patient?

A1. We utilize the expertise of actuary companies that develop the Medical Fee Schedule for Physicians. Other resources are The Centers for Medicare and Medicaid. The Medicare Cost Report includes all billing information and is the reason it is used to establish the base cost-to-charge ratio. Inaccurate reporting to Medicare/Medicaid could leave a provider with serious legal consequences. Hospitals are required to "bill/charge" everyone the same. Hospitals may agree by contract to accept different payments.

Q2. Please define Acute Care. The regulation refers to "acute care" as long-term acute care hospitals, 400 licensed acute care beds. What determines which hospitals cost-to-charge ratio is calculated using 132% or 138%? The hospital directory published by the Cabinet for Health and Family Services has a bed breakdown for each hospital. The bed breakdown list includes "acute" beds and 10 other types of beds, that includes other types of "acute" beds.

A2. "Acute care", in general, is defined as health care in which a patient is treated for a specific episode of illness, injury, or recovery from surgery. Acute care is usually delivered in a hospital setting.

An "Acute Care Hospital" is defined as a facility providing medical and/or surgical services to all individuals that seek care and treatment, regardless of the individual's ability to pay for such services. Acute care hospitals are capable of providing care on an immediate and emergent basis

through an established Emergency Department as well as continuous treatment on its premises for more than twenty-four (24) hours.

"Acute care beds" are assigned for less than a 25 day stay. After that, they are designated as long term.

A hospital that has more than 400 licensed acute care beds or a hospital that is designated as a Level I trauma center by the American college of Surgeons shall have a return to equity by multiplying its base cost-to-charge ratio by one hundred thirty eight percent (138%). All other hospitals will allow for a return to equity by multiplying the base cost-to-charge ratio by one hundred thirty two percent (132%).

Q3. Will the DWC recalculate the new Hospital cost-to-charge ratio when this regulation is passed? Once this regulation is passed will the cost-to-charge for 2009 be recalculated per this regulation or will the regulation take affect with the calculations for 2010?

A3. Yes, DWC will recalculate the new hospital cost-to-charge ratio. New letters will be forwarded and the website will be updated immediately.

Q4. What determined the use of 132% and 138% for calculating the cost-to-charge ratio, instead of the 12% that is currently allowed in the current regulation?

A4. The "12%" is not a true 12% add on. By application, this has become a .12 add to the base cost-to-charge ratio. Based upon this .12 add, the actual percentage of return varies from 117% of the base to 196% of

base. A higher return was considered appropriate for larger hospitals because of the higher percentage of complicated medical treatments rendered by the larger facilities.

Q5. Currently there are 12 facilities on the cost-to-charge list that have only acute rehab, CPR (Comprehensive Physical Rehab) beds or is a long term acute care hospital (see the list below). When calculating the cost to charge ratio for a new hospital, will the cost to charge ratio for those facilities be removed from the calculation of the average cost-to-charge ratio for the state?

Facilities without acute beds are Cardinal Hill Rehabilitation Hospital, Cardinal Hill Specialty Hospital, Commonwealth Specialty Hospital, Continuing Care @ St. Joseph, Frazier Rehabilitation, Gateway Rehab Hospital-Florence, Gateway Rehab @ Norton, Healthsouth Northern KY Rehab Hospital, Healthsouth Rehab Hospital of Central KY, Oaktree Hospital @ Baptist Regional, Ridge Behavioral Health, and Select Specialty Hospital.

A5. If the hospital submits the Medicare Cost Report, a base cost-to-charge ratio is established. If they do not file one, their cost-to-charge ratio will be established by section (5)(b) or (c).

Q6. Will the average cost-to-charge for the state be calculated once per year when the new calculations are completed, to be used for ALL new hospitals that come into existence for that year?

A6. Yes.

Q7. Will the DWC provide a list of instate Ambulatory Surgery Centers with their cost-to-charge ratio, per the guidelines set forth in the amended Hospital Fee Schedule regulation? Will there be a separate list for hospitals and rehabilitation, psychiatric, long-term hospitals and ambulatory surgery centers?

A7. Yes. A list of these facilities per county. It is up to the commissioner as to which ones will be calculated.

Q8. How will the Out of State Ambulatory Surgery Centers be paid per the new regulation? Carriers will not have access to all the information set forth in the new guidelines. Will the DWC gain access to this information to calculate an out of state ambulatory surgery center cost-to-charge ratio?

A8. See change in regulation section (6)(3).

SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY.

For the reasons stated herein, the Department of Workers' Claims will make the following changes to the amendments in 803 KAR 25:091:

Page 2
Section 1
Lines 14-20

After "year.", insert the following:

(5) "Ambulatory surgery center" means a public or private institution that is:
(a) Hospital based or freestanding;
(b) Operated under the supervision of an organized medical staff; and
(c) Established, equipped, and operated primarily for the purpose of treatment of patients by surgery, whose recovery under normal circumstances will not require inpatient care.

Page 3
Section 3
Lines 13-14

After "HCFA-2552.", insert the following:

The adjusted cost-to-charge ratio shall be determined as set forth in paragraph (c) of this subsection.

Line 15

After "(c)", insert "1."

Lines 17-18

After "beds", insert the following:

as shown by the Office of Inspector General's website

Pages 3 and 4
Section 3
Lines 22-23 on Page 3 and 1-5 on Page 4

After "~~percentile~~]", insert the following:

2. If a hospital's base cost-to-charge ratio falls by ten (10) percent or more of the base for one reporting year, then the next year's return to equity shall be reduced from 132 percent to 130 percent or 138 percent to 135 percent as determined by paragraph (c)1. of this subsection. This reduction is subject to an appeal pursuant to Section 4 of this regulation. The Commissioner may waive the reduction for no more than one (1) consecutive year.

Page 4
Section 3
Line 17

After "Services.", insert the following:

d. Has a base cost-to-charge ratio of fifty (50) percent or more.

Page 5
Section 3
Lines 6-8

After "ratio", insert the following:

after removing any duplicative charges or billing errors/charges for services or supplies not confirmed by the hospital chart.

Page 6
Section 5
Lines 19-22

After "located;", insert the following:

or

The adjusted cost-to-charge ratio of the hospital if the center is hospital based and is a licensed ambulatory surgery center or outpatient facility and is a Medicare provider based entity; and

Page 7
Section 6
Line 9

After "Hospitals", insert "and Ambulatory Surgery Centers".

Lines 10-11

After "hospital", insert "and ambulatory surgery center".

Lines 17-20

After "HCFA 2552.", insert the following:

(3) Out-of-state ambulatory surgery centers having no contiguous Kentucky counties shall be assigned a cost-to-charge ratio equal to seventy (70) percent of the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals.

Respectfully submitted,

Thomas A. Dockter
Staff Attorney
Department of Workers' Claims